Proposal Cover Page

Name of Proposal: **Neighborhood Nurse Practitioner Clinics**

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Signatures of those authorizing the submission of the proposal:

a) Comprehensiveness[1]

(1) What problem does this proposal address?

This proposal addresses how to provide affordable health care to people with no health insurance.

(2) What are the objectives of your proposal?

This proposal is a component of comprehensive health-care reform that minimizes the role of private insurance companies. Some proposed health-care reform measures in other states mandate that citizens buy private health insurance. This is absolutely the wrong approach, because the private insurance industry is the problem, not the solution.

In the past 30 years (since the Reagan Administration and its massive deregulation), the private insurance industry has instituted 4 practices that discriminate against customers while maximizing company profits. First, CEO and managers' salaries have skyrocketed out of control. For example, the CEO of United Health was paid $125,000,000 in the year 2005 alone. Second, most customer insurance premiums are raised every year, even for customers who have submitted no claims. Third, insurance companies have limited patient choice by specifying what physicians they can visit. Fourth, insurance companies specify what treatments/ procedures they will pay for, intruding into the relationship between doctor and patient.

As a result of the steadily climbing premiums for more limited and restricted service, many people have dropped their health insurance, and are now "out of the system." This status means they have no regular health care provider, and avoid seeking medical care, often until it is too late. Thus, the huge numbers of uninsured people today are the direct result of private insurance companies' business practices. Forcing all of Colorado's citizens to purchase private insurance will only increase the problem, rather than solve it.

In contrast, this proposal cuts private insurance companies out of the loop, leaving them only a niche market for catastrophic health care insurance. Meanwhile, normal, day-to-day, noncatastrophic, front-line health care and maintenance should be provided by direct contract between neighborhood patient groups and low-cost, neighborhood-level clinics staffed by Nurse Practitioners.

b) General

(1) Please describe your proposal in detail.

The proposal is to create numerous nurse-practitioner-run clinics (hereafter, Clinic) in neighborhoods, to serve the uninsured and under-insured. A Nurse Practitioner (hereafter, NP) is a health care provider with education and skills similar to a physician. In Colorado, NPs have prescriptive authority. Each Clinic would provide front-line, primary health care, maintenance, and screening for a group of member households (hereafter, called the Neighborhood Group). The Neighborhood Group would be limited to 500 households, all in a small contiguous area.

[1] See "comprehensive" in Definitions.

To become a member of the Neighborhood Group, a household must sign an annual contract with the Clinic to pay a flat rate of $25.00 per month to the clinic. In return for this payment, member households are allowed unlimited, free office visits with the NP at the Clinic. The Clinic will charge members at cost for laboratory tests. Patients will pay for their own prescriptions at the dispensing pharmacy, as usual. Therefore, there is no charge for office visits.

At the fully-subscribed level of 500 households paying $25/month, the NP Clinic is earning $12,500/month, so it does not need to charge individually for office visits. This income level is sufficient to cover the NP salary, a part-time office person, and general overhead expenses (including malpractice insurance). To minimize overhead costs, the Clinic operates out of a residential house in the neighborhood.

The Clinic, based on its existing rural role model, will provide primary care for acute problems and chronic diseases.

Patient visits with the NP may last between 30 minutes and 1 hour. This time span is much longer than an MD typically spends with a patient (5-10 minutes). During these extended office visits, the NP gets to know the health history of the patient, their relative's health history, the patient's current health and lifestyle, etc. The NP and her Clinic are an integral part of the neighborhood.

For such low- and medium-income patients, the concept of paying $500/month and up for private health insurance ($6000/year) makes no sense, because: (1) in an average year they spend less than 10% of that amount on health care, and (2) at the poverty level of $13,000/year, such insurance would consume half their income! No wonder they don't have private health insurance. So, either they have made the economic decision not to buy insurance, or they are uninsurable for one reason or another.

This system is founded on a direct contract for services between the patient household and the health care provider (NP) who owns and operates the Clinic. There would be no insurance involved, and hence no insurance requirements, no denials of coverage, no co-pays, no deductibles.

In order to keep costs down, this Clinic should be housed right in the neighborhood that it serves, in a residential building. The Nurse Practitioner rents or owns the building, and uses some of the rooms for the Clinic and others for office.

(2) Who will benefit from this proposal? Who will be negatively affected by this proposal?

The primary beneficiaries of this system would be the uninsured, who will be able to obtain near at-cost health care any time they need it. In other words, since the office visits are free, they will not postpone a visit to the Clinic because they are worried about the cost. Because the system does not rely on tax money or insurance money, nobody is negatively affected.

(3) How will your proposal impact distinct populations (e.g. low-income, rural, immigrant, ethnic minority, disabled)?

This system was devised for a rural, low-income setting, where a typical office visit at a "mainstream" health care facility costs $75-85, a significant sum to those making only poverty-level wages. But the system will work in any geographic area with large numbers of people without health insurance, or with high-deductible insurance.

(4) Please provide any evidence regarding the success or failure of your approach. Please attach.

This approach has not been validated. It is based on the success of a rural nurse-practitioner-run clinic in Crestone, Colorado, which currently bills on a per-visit basis. HOWEVER, the system is similar in concept to the new phenomenon of "in-store" health clinics found at Walgreens and Wal-Mart stores across the country, which are also staffed by Nurse Practitioners (see www.takecarehealth.com). This new trend proves that NP-run clinics can function as stand-alone, front-line health care providers.

(5) How will the program(s) included in the proposal be governed and administered?

The NP at the Clinic keeps her own records. That is the total extent of "government and administration." There are no administrators or other middlemen drawing salaries in this system. Patient fees go directly to the provider.

(6) To the best of you knowledge, will any federal or state laws or regulations need to be changed to implement this proposal (e.g. federal Medicaid waiver, worker's compensation, auto insurance, ERISA)? If known, what changes will be necessary?

No laws or regulations at any level need to be modified for this system. The Clinic does not take Medicaid, Medicare, or any type of insurance. It is based solely on an annual private contract for health care between member households and the provider.

(7) How will your program be implemented? How will your proposal transition from the current system to the proposal program? Over what time period?

This system could be implemented at any time, because it is based on a private contract with no involvement of government or insurance companies. To be implemented at the least overhead cost, the Clinic would have to be a "commercial" use in a residentially-zoned neighborhood. Members could walk to the Clinic in that case; no Member would live far away. They would not have to burn up gasoline driving to a clinic halfway across town. But to function this way, it would require the Clinic to receive a conditional use permit or a variance from the local government.

If such a variance could not be obtained, then the Clinic would have to be located in the nearest commercially-zoned area to the 500 family Neighborhood Group. This would add rent and utility costs for office space, meaning that to cover those costs, either the number of households in the Neighborhood Group would have to be increased, or the annual cost to each member would have to be increased. However, there is some flexibility here, since the household is now only paying on the order of $25/month for unlimited visits for an entire family.

c) Access[2]

(1) Does this proposal expand access? If so, please explain.

Access to the Clinic is open to anyone who pays the annual contract amount, and who lives in the defined Neighborhood. There are no other restrictions. As currently practiced in the rural role model clinic, the NP commonly provides normal services such as scheduled daytime office visits. However, she also provides two services that are not available through the mainstream health care delivery system. First, she commonly receives phone call for help from neighborhood patients after 5 pm. These calls range from requests for advice, to requests for urgent care. She always gives the advice, sometimes she permits the patient to come to the clinic for rapid care. Often she advises the patient that the best option for their particular crisis is an immediate trip to the Emergency Room. However, the important fact here is that the patient calling after 5 pm does receive some kind of advice or care. Not just an answering machine.

Second, the NP makes occasional house calls to housebound patients in the Neighborhood Group. This is possible, for a fee surcharge, because the NP is part of the neighborhood. I daresay that the above two aspects of neighborhood-based health care have all but disappeared from America since the ascendance of mainstream, "corporate-run" health care. But it's time to bring them back.

(2) How will the program affect safety net providers[3]?

The Clinic is a new safety net provider, of a type that does not currently exist. Unlike existing safety net providers, however, it operates with no federal or state subsidies. The system provides a front-line, early response safety net for underserved or underinsured people who are currently "out of the health care system." See the example cited in the Benefits section, below.

d) Coverage[4]

(1) Does your proposal "expand health care coverage[5]?" (Senate Bill 06-208) How?

The system does not involve "coverage" as defined by the State, because it does not involve third parties. Instead, it is based on a direct contract for services between the

[2] See "access" in Definitions.
[3] See "safety net provider" in Definitions.
[4] See "coverage" in Definitions.
[5] See "expansion of coverage" in Definitions.

patients and the NP. Anyone in the Neighborhood geographic area is free to join, and will be accepted as long as they can pay the low monthly fee.

(2) How will outreach and enrollment be conducted?

Outreach will be by limited local advertising, but mainly word-of-mouth in the neighborhood. Enrollment will be by direct contract between a household and the Clinic.

(3) If applicable, how does your proposal define "resident?" N/A

e) Affordability

(1) If applicable, what will enrollee and/or employer premium-sharing requirements be?

The Members pay a flat monthly fee to maintain membership. There is no insurance of any kind, no co-payments, no premiums, and no cost-sharing of any kind with third parties.

(2) How will co-payments and other cost-sharing be structured?

f) Portability

(1) Please describe any provisions for assuring that individuals maintain access to coverage[6] even as life circumstances (e.g. employment, public program eligibility) and health status change.

There is no way a Member can lose eligibility for Membership, because there are no 3rd parties involved. If they can pay, they can be Members. However, if the household develops a serious medical condition than requires expensive surgery and inpatient care, then obviously the Clinic cannot provide such services. In such a case, the household should start shopping for insurance. The Clinic cannot substitute for catastrophic health care insurance.

g) Benefits

(1) Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations.

The benefits of this system are greatest for basically healthy people who occasionally need medical treatment, and/or preventative counseling, but who generate so little in medical costs per year that they not only don't have health insurance, they don't even have a regular (primary) health care provider. They don't have chronic illnesses, and are loathe to pay $500/month and up for health insurance, when their yearly medical expenditures are less than that amount. As a result, they are "out of the system." No health care professional hardly ever sees them, or has the opportunity to counsel them with any continuity. Since they have no health insurance or regular provider, they tend to

[6] See "coverage" in Definitions.

postpone visits to a clinic when symptoms arise, trying to save money. Two things result from this situation: (1) patients tend to continue harmful lifestyle habits, without ever being told by a health care professional that they need to stop it, and exactly what will happen if they don't stop, and (2) untended symptoms from these habits, plus occasional acute infections that they pick up, can grow and develop into serious, life-threatening situations.

Case in point: A normally-healthy 50 year-old woman with no health insurance was experiencing discomfort of the groin area. She thought it might be the beginning of a urinary tract infection (which in fact, it was), but due to lack of insurance, and a regular health care provider, she attempted to treat it herself at home with various herb teas and over-the-counter pain medicines. This went on for more than a week, and seemed to be getting a bit better, or at least no worse. Then after about 10 days, she had a relapse and developed severe symptoms. She made an appointment at the closest rural clinic (20 miles away), and when she got there and was seen, she was sent immediately to the emergency room of the nearest hospital (35 miles away), to be treated for sepsis in an Emergency Room setting. This life-threatening, expensive situation would not have occurred if the woman had access to unlimited free office visits to a Neighborhood Clinic not far from her home, staffed by an NP who knew her health history and normal health state.

(2) Please identify an existing Colorado benefit package that is similar to the one(s) you are proposing (e.g. Small Group Standard Plan, Medicaid, etc) and describe any differences between the existing benefit package and your benefit package.

There are no existing "benefit packages" like this currently in Colorado. The only thing similar is a situation where uninsured people have a primary health care provider who is an MD who owns his own small, private practice (1-3 providers). However, the MD charges much more for his services (office visits) than in this model, because of his educational expenses and overhead expenses; he is normally not located in the neighborhood, so patients have to drive to him; and each office visit must be paid for separately (unlike in our plan).

h) Quality

(1) How will quality be defined, measured, and improved?

The quality of the program is defined by and maintained by the NP, who is the sole health care provider. NPs are licensed by the State to practice, and certified by national certifying bodies. These bodies have certain requirements for Continuing Education in order to maintain certification. As in all free-market transactions, if the Member feels that the quality of service is not up to his or her standards, they are free to stop purchasing the service.

(2) How, if at all, will quality of care be improved (e.g. using methods such as applying evidence to medicine, using information technology, improving provider training, aligning provider payment with outcomes, and improving cultural competency including ethnicity, sexual orientation, gender identity, education, and rural areas, etc.?)

i) Efficiency

(1) Does your proposal decrease or contain health care costs? How?

The proposed system is very cost effective, because the patients are paying only for the salary of their health care provider, and not for "middlemen" such as CEOs, CFOs, administrators, insurance billers, medical records keepers, trainees, secretaries, technicians, janitors, etc. The patient will never be put in the position of paying much of his fees to support outrageous CEO salaries, such as the annual $125,000,000 salary (2005) of the CEO of United Health (cumulative salary over the past 5 years, $350,000,000).

(2) To what extent does your proposal use incentives for providers, consumers, plans or others to reward behavior that minimizes costs and maximizes access[7] and quality in the health care services? Please explain.

The system has the maximum incentive for patients to visit the Clinic any time they want, because: (1) they have already paid their monthly fee, so if they don't use the Clinic, that money is wasted, and (2) there is no financial cost to making multiple office visits, as opposed to a single visit. This permits follow-up visits, which normally a poor patient would be reluctant to pay for. Some poor patients believe that when an MD suggests a follow-up visit, "to see how the patient is doing", he is just trying to double his income. So they may schedule a follow-up visit, but they never show up. In actuality, the practitioner can monitor the health state of patients much better if follow-up visits occur, so she can see the effect of the treatment prescribed. For maintaining a good health state in patients with chronic (but not life-threatening) conditions such as hypertension, diabetes, severe allergies, etc., follow-up visits are mandatory. Our proposed system encourages follow-up visits; the mainstream health care system in place today does not.

(3) Does this proposal address transparency of costs and quality[8]? If so, please explain.

All patients will know their NP personally, and will know this: every dollar that they pay goes directly to the provider, and not to any middlemen or insurance companies. They will know that they are paying the exact cost for lab tests, with no add-on profit to the NP.

(4) How would your proposal impact administrative costs[9]?

There are no administrative costs. The NP maintains her own patient files.

[7] See "access" in Definitions.
[8] See "transparency" in Definitions.
[9] See "administrative costs" in Definitions.

j) Consumer choice and empowerment

(1) Does your proposal address consumer choice? If so, how?

The consumer has total choice whether to join the Neighborhood Group or not.

(2) How, if at all, would your proposal help consumers to be more informed about and better equipped to engage in health care decisions?

Because patients can visit the Clinic any time, and their "face-time" with the NP during an office visit is much longer than usual (in the USA), there is much more communication and feedback than normal. Thus, there is much more opportunity for the NP to explain causes of illness and treatment options, than in the "mainstream" health-care delivery system.

k) Wellness and prevention

(1) How does your proposal address wellness and prevention?

This system is better than the existing "mainstream" system of health-care delivery, in regards to wellness and prevention, in three ways. First, as explained above, the longer office visits permit the NP to become much more aware of her patient's health history than is normal. Second, the more frequent visits that a patient can make, without incurring additional charges, accomplish the same thing. Third, the NP lives in the neighborhood, so she KNOWS the patients. The NPs children may go to the same school as the Member's children. In fact, the NP may know facts about the patient's lifestyle that the patient would not normally even tell a physician.

l) Sustainability

(1) How is your proposal sustainable over the long-term?

(2) (Optional) How much do you estimate this proposal will cost? How much do you estimate this proposal will save? Please explain.

In its simplest form, this proposal would not cost anything to the State, because it is a private contract between patients and providers. The NP is making a living wage, and the Members get unlimited office visits for a low monthly fee.

There are several ways that the State could assist the rapid growth of Neighborhood Clinics, however:
1—for young NPs, provide a loan program to NP students for their schooling (Masters Degree in Nursing). After graduation, if the NP opens and operates a Neighborhood Clinic, the loan is progressively forgiven.

2—for older, experienced NPs, provide a low-interest (sub-prime) loan program or loan guarantees to assist them in purchasing the residence from which to operate the Clinic.

3—**Combining Neighborhood NP Clinics with State-Provided Insurance**: this novel idea combines the front-line, maintenance health care provided by the Clinic, with State-provided Emergency and Specialist Care beyond the Clinic's scope. If the State gets into the business of providing or underwriting health insurance, it should also want to

minimize the financial demand on its system. The best way to do this is by preventing unnecessary patient visits and procedures. In other words, the State should want to reward Coloradans who conscientiously take care of their health. One easy way to do this is for the State to grant discount coverage to people who belong to a Neighborhood Clinic Group, and use it's services at least once a year. In this way, the Neighborhood Clinics act as an "early-warning" system to catch health problems, before they become acute, and before they require expensive Emergency or Specialist Care, which the State would end up paying for.

(3) Who will pay for any new costs under your proposal?

Almost all new costs will be borne by the members of the Neighborhood Group.

(4) How will distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increased or decreased costs? Please explain.

For individuals who currently have no health insurance, and receive all their health care from Emergency Rooms, this system may actually save them money. For example, an Emergency Room visit can cost up to $1000. By comparison, at $25/month to belong to the Neighborhood Group, a person could purchase 40 months of basic health care for $1000. This proposal would relieve employers of the burden of providing health insurance for their employees. The proposal requires very little in the way of Government funding, since it is mainly a private contract. The Neighborhood Clinics could actually save the State money, by catching health problems before the develop unnecessary complications that require Emergency Room treatment.

(5) Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal? Please explain.

No mandates; the system is entirely voluntary.

(6) (Optional) How will your proposal impact cost-shifting[10]? Please explain.

(7) Are new public funds required for your proposal?

Only if the State decides to initiate one of the loan programs mentioned above.

(8) (Optional) If your proposal requires new public funds, what will be the source of these new funds?

1. A single page describing how your proposal is either comprehensive or would fit into a comprehensive proposal

See section (a) Comprehensiveness, on page 2.

2. (Optional) A single page describing how your proposal was developed.

Based on an existing rural NP clinic in southern Colorado.

[10] See "cost-shifting" in Definitions.